Child Healthy Weight Self Referral Form

Name: _____ **Date of referral:** ___/___/___

Date of birth: ___/___/_____

Address: **Parent/Guardian Telephone:** **Parent/Guardian Email:**

Gender - Please tick		
☐ Male	☐ Female	☐ Do not identify as male or female

Please indicate which pronouns the child/young person prefers:

☐ He/him ☐ She/her ☐ They/them

Will you need an Interpreter? Yes ☐ **No** ☐ **Language:** _____

Reason for referral –what do you hope to achieve by attending the service? **Any physical disabilities or emotional wellbeing concerns that would be helpful to share?** **Any concerns about potentially attending a group?**
Child/Young person/Parent/Guardian's signature:

If you would like to discuss the referral with us or need help filling it out, please contact us on 0131 537 9169 or email at: loth.childhealthyweight@nhslothian.scot.nhs.uk

Thank you for completing this form. Please either post it to: Lothian Weight Management Service, Woodlands House, Astley Ainslie Hospital, Canaan Lane, Edinburgh, EH9 2TB OR email us at: loth.childhealthyweight@nhslothian.scot.nhs.uk